Chapter 5

Becoming an art therapy practitioner

Annette Coulter

Graduating art therapists are beginning a new phase of their career, aiming to build on ideas and gain clinical experience by working with a range of clients. However, there may be challenges, such as pioneering art therapy in professional isolation, for example, when overseas graduates return home or choose to work in a remote location. Seeking work where art therapy services are not established requires acquiring an additional set of skills. This chapter offers advice and ideas for becoming an art therapist practitioner, particularly when working without the professional support systems recommended for best practice.

Success for the overseas graduate relies on the art therapist's core sense of identity, a belief in the unique service they offer and their ability to self-market and to educate professional communities as well as the general public. They need to be able to reframe a lack of understanding and support into a challenge to educate and promote their specialist skills and competencies. Rehabilitative communities available, although the current dominant discourse is mostly British or North American and there is little provision to equip graduates to sell their credibility, validate their clinical effectiveness or adapt art therapy to other cultural contexts.

Establishing a training programme

Overseas graduates returning home may have a choice of either securing employment or establishing a professional training programme. Once local art therapists have earned professional credibility, educational authorities are more likely to approve a training programme. Course instigators have to translate art therapy course content to a new cultural context, and foreign art therapists may have limited knowledge of local issues and systems, though some have supported the establishment of new training courses (Hagood 1993;; Gilroy and Hanna 1998;; Campanelli and Kaplan 1996;; Slater 1999;; Coulter 2006b). However, in most (Potash, Bardot and Ho 2012).

Finding employment

Finding art therapy employment may not always be possible. The following employment or enhance better workplace terms and conditions.

Offering a 'taster'

Some potential employers may prefer to be offered a session or short series of be negotiated and a short-term group or a professional development presentation offered (see

Chapter 6). Information about an art therapy initiative can therefore be passed on through interagency networks and may lead to further work.

A trainee internship/placement

Art therapy can be introduced through offering a clinical placement or internship, which may be useful for agencies with limited funding, and can lead to employment possibilities in cautious clinical environments.

Extended clinical placement/practicum

placement. When establishing a training programme, matching the student to the agency often determines the short-term future of art therapy in that facility. The workplace can see the effectiveness of the work and becomes convinced that initiating a compromised art therapy position, such as a part-time or a time-limited contract. The art therapist needs to avoid slipping into their previous traineeship role and has to place remunerative value on the service they offer. They need to negotiate responsibilities and make recommendations to the job description in line with professional requirements, aware that, for example, their on-site clinical supervisor is now their line manager.

Generating funding

After a short block of 'taster' sessions have been delivered, a decision can be service industry. The funds available may not be commensurate with industry media in response to the funding gesture. Pioneering a new profession often means

Promoting a previous qualification

Sometimes it is more useful for art therapists to play down their specialist skills and their previous job title, and can then build up a designated 'art therapist' position.

Negotiating a job description

may have other job titles such as 'counsellor', 'case worker', 'child' or 'family' successful employment, there is often no provision for demonstrating these attributes within the existing job description. When negotiating terms of employment, it pays to delineate between administrative and clinical responsibilities;; the art therapist carries direct clinical responsibility even though their administrative accountability is to other staff.

Establishing an art therapy service

dictate their employment, especially if they are working in professional isolation. A new art therapy service must earn respect, particularly in a system that values medication, cognitive interventions and diagnostic statistics. Art therapists themselves need to respect and understand other traditional interventions. Mutual acceptance assists such things as

the designation of an ‘art therapist’ position, salary improvement, better work facilities, the purchasing of art equipment and establishing an art therapy referral system.

Referral

The best treatment conditions are where the art therapist has direct contact with the referral source. Establishing a direct referral system builds professional respect. In medical settings, the specialist is the direct referrer but it might also be a unit director or another service. The referrer is directly informed through an assessment process about case suitability for art therapy treatment, taking into account not only the treatment offered, but also the therapist’s scope of clinical experience.

The advantage of direct referral is that a relationship is established between more about art therapy treatment, case discussion can become increasingly complex and skills and expertise within the working relationship expand. The referrer gains a better understanding about how art therapy might assist their clients’ psychopathology and when the art therapist’s skills are appreciated, there are further referrals and recommendations to other networks. Gradually, the art therapy service becomes indispensable as a treatment modality.

Art therapy assessment

An assessment phase provides an opportunity for not only the therapist to assess the client’s therapeutic needs, but also for the client to assess whether the therapist can help them.

An assessment is instigated primarily to determine the appropriateness for than the client. Referrers more easily accept case unsuitability if an assessment process has taken place. An assessment also assists case management where legal documentation is required.

There is often a misunderstanding that through providing an assessment, the art therapist diagnoses pathology. Art therapists are not trained to diagnose and assessments should never take the place of therapy. Through image content, the assessment determines self-perception, psychomotor activity and unconscious expression through images. Art tasks tap directly into how the maker perceives their visual world;; often clients may not be able to say in words what can be described through image production.

administered. The client needs to understand that this is not therapy but is an only by what is said by the client. In order to avoid litigation, it is important when documenting client statements to quote directly what is said. Recording the image assists ease of review – for example, an unnoticed theme becomes evident when the artwork is regarded as one completed body of work. Assessment requires a distinction between what is observed during the art procedures and what is projected by the client and/or hypothesised by the therapist. Expressive components such as sequence, size, pressure, stroke, detailing, symmetry, placement and motion show *how* artwork is executed and content components describe *what* is drawn.

Some art therapists are able to administer specific art therapy assessment procedures, whereas others focus on the level of initial engagement and the monitoring of conscious and unconscious processes within the therapeutic relationship (Case and Dalley 1992; Gilroy, Tipple and Brown 2012). The following assessment procedures can help work colleagues understand art therapy; they are easy to explain, administer and are effective.

The Kramer Art Evaluation

Edith Kramer developed one of the earliest art therapy assessment procedures that is still widely used (Kramer and Schehr 1983). In this procedure, the client is given three non-directive art tasks: painting, drawing and clay-work, and is instructed: 'I am going to ask you to make three pieces of art today with the materials provided for you. You are to draw, paint, and use clay in whatever order you choose, and you may choose the subject matter. I will ask you a few questions when you are finished all three tasks.' (Kramer and Schehr 1983).

Ulman Assessment

The Ulman assessment procedure includes an optional scoring system for the quality of marks made. Art materials include grey paper and a new set of chalk pastels. Instructions include:

- i You will be making four drawings. Please use these materials to make your
- ii Follow me in these exercises (physical warm-up);; now make these same movements with chalk on paper.
- iii With your eyes closed, make a rhythmic scribble on this piece of paper. Look for images in the scribble. You may see one, you may see several. Select the images you wish to develop into a picture. You may use the lines already on the paper, colour over them, ignore them, change them, or add lines.
- iv This will be your last picture. You have the choice of making a picture from a scribble or of making a picture as you did originally – directly on the paper. (Ulman 1975:362–5)

The Diagnostic Drawing Series (DDS)

The DDS is a systemic approach to art therapy evaluation and research, originally designed as a format for the study of drawings in relation to diagnosis (Cohen, Hammer and Singer 1988).

Three pictures are produced that reflect how an individual responds to structure and directives, allowing for a range of psychological and graphic responses. Art materials are a set of drawing pastels and a piece of 18" × 24"paper. There are three tasks, after each of which the client is asked a series of questions.

TASK 1: MAKE A PICTURE USING THESE MATERIALS (UNSTRUCTURED)

Can you describe this picture? Can you tell me what the colours mean? Can you tell me what these images mean or represent? What else would you like to say about the picture? What would you title the picture?

TASK 2: MAKE A PICTURE OF A TREE (STRUCTURED)

Can you describe this tree? Is this a tree you know or is it imaginary? Where would it be located? Are there special meanings to the colours? What part of the tree do you like best? What part of the tree do you like least? What else would you like to say about the picture?

TASK 3: MAKE A PICTURE OF HOW YOU ARE FEELING USING LINES, SHAPES AND COLOURS (STRUCTURED)

Can you describe this picture? Can you tell me what these colours mean? Can you tell me what these images represent? What would you title this picture? (Cohen, Hammer and Singer 1988).

Designing an art therapy assessment

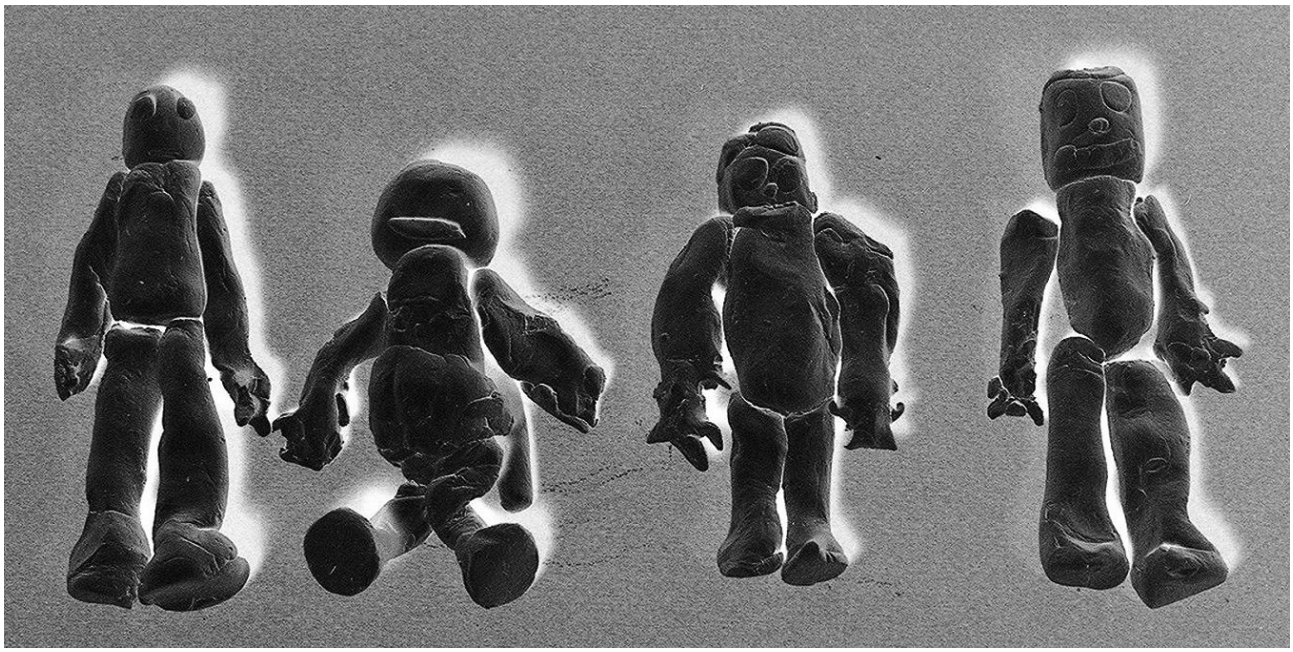
There is a real skill in being able to design an assessment to specifically suit client needs. The following ideas can be used.

- *A 'free' picture:* The client is invited to 'draw whatever comes to mind'. A free 1978; Ulman 1975; Cohen, Hammer and Singer 1988). This open-ended task provides a choice of content and art media to determine the client at the outset of therapy. Artistic merit is not the primary interest (see Chapter 6).

- *A family picture:* This task can begin with an instruction such as 'draw your family, including yourself, as animals' or a more complex task such as 'draw an abstract family portrait' (Kwiatkowska 1978). Alternatively, a This could be an action-oriented task, for example, 'draw everyone in the family, including yourself, doing something' (Burns and Kaufman 1970:5). The family can do more than one art task together (see Chapter 12). Media tends to favour oil pastels, but three-dimensional media such as clay can also be used (see Figure 5.1).

- *The problem:* The purpose of this task is to determine the client's ability to visually conceptualise the problem. The task might be, 'draw a picture of the problem, as you understand it'. However, a more specific instruction might be required, such as 'draw this recurring dream', or 'draw how this person makes you feel'. This task is not always suitable because the client may have no concept of why they feel the way they do, or may not believe there is a problem. Therefore an image about feelings might be more appropriate;; for example, if they feel depressed, 'in some way can you put those feelings onto the paper?'

- *Figure 5.1* My family, by Elizabeth, age 8



- *Self-image:* Self-concept tasks are nearly always relevant where issues of self-esteem are affecting mood and especially in the assessment of young people. A task might simply be ‘draw a picture of yourself’, or could be more complex, such as ‘draw how others see you.’ It could be symbolic: ‘draw yourself as a tree/animal/object, with any qualities, any colour’;; or abstract: ‘describe yourself in shape and colour only’, or extended to ‘... so that when you look at the picture, it conveys a sense of who you are at this point in time’. The task can also be contextual or diagrammatic, such as ‘draw your life as a map, up until now’. A mirror can be used for realistic self-portraiture (Ault 1999).

- *Future focus*: The inclusion of a future-focused task helps determine goals of treatment, contributing to the therapist’s contract with the client. Formulating clear goals might be an agreed condition of treatment. The art It could also be something like, ‘draw how your life/you would be, if you no longer needed to come to therapy’. The task can incorporate the ‘Miracle Question’ where the client is invited to imagine their life problem-free: ‘if a miracle happened, how would your life be different?’ (de Shazer 1994: 95). The art therapist then adds, ‘can you draw that?’ (Coulter 2011:88) This task

- *A 'free' picture:* The invitation to complete a final 'free' picture helps indicate how the assessment procedure has affected the client's sense of well-being. Comparing the first and last 'free' picture is informative (Kwiatkowska 1978; Ulman 1975).

how the assessment procedure has affected the client's sense of well-being. 1978; Ulman 1975).

Generally, client suitability is determined and rapport and safety can be reasonably established after three sessions. The art therapist might choose to extend the assessment to six sessions to consolidate their initial impressions or restrict it to two or three sessions if there are only six to twelve sessions available because of funding, health insurance or agency in-take policy. Some therapists have longer initial sessions, so that the assessment is completed in one or two two- hour sessions. An assessment report determining appropriateness for art therapy is sent to the referrer after the initial contact sessions are completed.

Writing reports

Anything written about a client is a legal document. It is therefore important to only document facts, not unsubstantiated subjective comments. A written report to the referrer is usually required on completion of an art therapy assessment, particularly pro-forma for report-writing that includes client information provided at the time of referral;; the number of sessions to date; a brief history; initial impressions; in the case of a family, who was seen and the frequency; nature of the assessment or and comments; recommendations; further treatment; and concluding remarks.

Client self-evaluation can be a spontaneous gesture drawing in a visual diary at the beginning and end of each therapy session (see Chapter 7). Alternatively, client feedback can be the completion of a brief form at the termination of therapy, including a question about using art materials in this context.

Designing forms and policies

practice, especially in a sole worker service. For best practice, the following should be included: referral; client evaluation/feedback; exchange of information;; consent to be recorded; consent that art work can be shared or used for educational purposes, or permission to exhibit client artwork.

Referral forms

Collaborative team work

has the advantage of joint case management, and the possibility of working with work with extended family members such as parents, grandparents or siblings of the client or another family sub-system.

Ownership and ethical responsibility

Consent forms are always required to share art work in clinical or educational settings, although it is often questionable whether the client can refuse such requests. It is not always in the client's best interests for art work to be shared with other team members, parents or the doctor, particularly in the case of child art therapy. Because signed permission is given, the art therapist meets their ethical obligation although the client's motivation to sign a release form is often to please their therapists rather than in their own best interest. However, art work display can demonstrate art therapy's effectiveness as well as provide therapeutic gain (Coulter 2008). There are limitations indicate destructive intent to self or others, and it is mandatory to report disclosures of abuse or intention to self-harm or others.

Professional indemnity insurance

When employed within an agency, professional indemnity is usually part of the employment package, whilst in contract work the art therapist must have personal indemnity insurance for session work. Some professional membership is conditional on the therapist maintaining up-to-date indemnity insurance cover. This protects the art therapist from personal liability regarding a client complaint.

Private practice

It is better to consolidate training through successful agency employment before establishing private practice. Training courses recommend supervised post- training clinical practice to gain experience because there is no back up in private practice. Where there are limited employment opportunities, however, private practice can become a necessity.

Remuneration as a private practitioner is likely to be greater than agency work but there is greater clinical responsibility and larger overhead costs, such as indemnity and third party liability insurance, and hiring private rooms which can be costly particularly if an art studio is required. It is sometimes easier to invest in purpose-built rooms or to establish practice rooms from home. Working from a counselling room located at a private residence may present boundary issues and for some is not viable. Where counselling rooms are rented or shared, there may be constraints on art media usage and the degree of mess that is manageable.

In some countries, counselling, including art therapy, is subsidised through a rebate scheme or health insurance. In other countries, private health funds support alternative programmes including art therapy and sometimes these apply art therapy services, although there are special circumstances where government services fund client art therapy treatment.

Personal dress code

In health settings an 'arty' look does not earn the same respect as that of someone advantaged if they consider their professional persona, including how they dress. A professional dress code also affects clients' perceptions of the art therapist. For example,

no visible cleavage assists the management of sexual transference onto an undiagnosed foot or toe fetish. Imposing personal beliefs onto the therapeutic relationship through attire is problematic. For example, wearing religious symbols some cultures there are demands of dress such as the burka, the yarmulke or a turban. The potential impact of personal dress on the therapeutic relationship can be managed through clinical supervision.

Owning the name 'art therapy'

When delivering short training workshops to workers who already claim to 'do a bit of art therapy', it's helpful to mention that art therapy is a post-graduate specialist training and that everything cannot be taught in a one-day workshop. Where other professionals are using art techniques, confusion is avoided by encouraging that they call this 'creative art', 'art and self-expression', 'creative expression' or 'art and personal growth'. When establishing a national association, the term of 'art therapy' can be claimed through government legislation.

Forming partnerships: other professional groups

The art therapist is sometimes eligible to join an association that has a more generic membership such as family therapists or counsellors and psychotherapists. Where registration for art therapy is not established, belonging to another organisation can assist in becoming a local registered practitioner, providing opportunity for professional development and skills-promotion. Conferences and training presentations can help educate others about art therapy practice (see Chapter 6). professionals, helps generate referrals and promote an art therapy service.

Establishing a national association

Professional respect, public education and opportunities for art therapy promotion are greatly enhanced through the establishment of a national organisation. An information centre can be set up that recommends the growth of art therapy in a particular country. Knowledge can be made accessible by translating into the local language. Founding members can promote a national understanding of art therapy through workshops and conferences, as well as short training courses.

founding group or steering committee consider: (i) a terms of reference; (ii) a purpose of intent; and (iii) formulate membership criteria. Policy documents need to be drafted: (i) a constitution; (ii) a code of ethics; (iii) a standard of practice; and eventually, (iv) training guidelines. Sometimes differences in overseas training local contexts. When founding members come from varied overseas training frameworks, the need for a more global appreciation of art therapy is required; difference requires integration and respectful compromise (see Chapter 17). An international perspective better supports the sole worker practitioner who is pioneering the profession in isolation.

Pioneering art therapy internationally involves integrating aspects of the to the art therapist's core beliefs and understandings. Global variances of the profession need to be

resolved from a perspective that is respectful of differences in practice. Although there are many aspects of becoming an art therapist, increasingly the challenge is to establish the profession in a resistive environment with few professional supports.

Bibliography

Ault, R.E. 1999. Drawing on the Contours of the Mind-Contour Drawing as a Psychotherapeutic Process. Keynote address, the Sixth International Annual Conference of the Korean Art Therapy Association, Seoul, Korea, October.

Burns, R.C. and Kaufman, S.F. 1970. *Kinetic Family Drawings*. New York: Brunner/Mazel. Campanelli, M. and Kaplan, F.F. 1996. Art Therapy in Oz: Report from Australia. *The Arts in Psychotherapy* 23(1), 61–7.

Case, C. and Dalley, T. 1992. *The Handbook of Art Therapy*. London: Routledge.

Cohen, B. M., Hammer, J.S. and Singer, S, 1988. The Diagnostic Drawing Series: a

Systematic Approach to Art Therapy Evaluation and Research. *Arts in Psychotherapy* 15(1): 11–21.

Coulter, A. 2006a. Art Therapy in Australia: The Extended Family. *Australian and New Zealand Journal of Art Therapy* 1(1), 8–18.

Coulter, A. 2006b. Art Therapy Education: No More Lip-Service to Cultural Diversity!

Panel presentation, International Networking Group of Art Therapists: Education Development, Current Practice and Research, American Art Therapy Association Conference, 16 November.

Coulter, A. 2008. 'Came Back – Didn't Come Home': Returning from a War Zone, in M. Liebmann (ed.) *Art Therapy and Anger*. London: Jessica Kingsley Publishers, pp. 238–56.

Coulter, A. 2011. Contemporary Art Therapy: Working with Transient Youth, in H. Burt (ed.) *Art Therapy and Postmodernism: Creative Healing Through a Prism*. London: Jessica Kingsley Publishers, pp. 83–93.

A.C. Calisch (eds) *Tapestry of Cultural Issues in Art Therapy*. London: Jessica Kingsley Publishers, pp. 249–75.

Gilroy, A., Tipple, R. and Brown, C. (eds) 2012. *Assessment in Art Therapy*. London: Routledge.

Hagood, M.M. 1993. Letter to the Editor. *The Arts in Psychotherapy* 20(4), 279–81. Kramer, E. & Schehr, J. 1983. An Art Therapy Evaluation Session for Children. *American*

Journal of Art Therapy 23, 3–12.
Kwiatkowska, H.Y. 1978. *Family Therapy and Evaluation Through Art. C.C. Thomas.*

Potash, J.S. Bardot, H. and Ho, R.T.H. 2012. Conceptualizing International Art Therapy Education Standards. The Arts in Psychotherapy 39, 143–50.

de Shazer, S. 1994. Words Were Originally Magic. New York: W.W. Norton and Company. Slater, N. 1999. Keynote Address (unpublished). Tenth Annual Conference of the

Australian National Art Therapy Association, Coming Full Circle: An Unfolding Journey, Brisbane, Queensland, Australia.

Ulman, E. 1975. The New Use of Art in Psychiatric Analysis, in E. Ulman and P. Dachinger (eds) *Art Therapy in Theory and Practice*. New York: Schocken Books, pp. 361–86.